AAA/CME _____
Assessor Name
_____
Assessor Phone
_____

Kansas Department on Aging

Uniform Assessment Instrument

Disaster Red Flag	
Electric	
Physical Impairment	
Medication Assist	
Cognitive/MH issues	
No Informal Support	
None	

Assessment Date :

Expedited Services : Yes _____ No _____

Customer Legal Name & Address: Nickname _____

First _____ M.I. _____

Last _____

Residence Address _____

City _____

County _____ State _____ Zip _____

Phone _____

Directions _____

_____

……

Mailing or Alternative Address

Street _____

City _____

County _____ State _____ Zip _____

Phone _____

Birth Date _____ / _____ / _____
month day year

Age _____ Male ____ Female ____

Marital Status: Single ____ Married ____
Widowed ____ Divorced ____

Veteran or Spouse of Veteran? Yes ___ No ___

Receive Veteran Benefits? Yes ___ No ___

Income below poverty level? Yes ____ No ____

Does Customer live alone? Yes ____ No ____

Customer's home is: Rural ____ Urban ____

Ethnicity: Hispanic or Latino ____
Not Hispanic or Latino ____
Ethnicity Missing ____

Race:	
White Non-Hispanic	
White Hispanic	
American Indian/Alaskan Native	
Asian	
Black or African American	
Native Hawaiian or Other Pacific Islander	
Reporting some other race	
Reporting 2 or more races	

Social Security # _____

Medicaid # _____

Medicare # _____

KAMIS ID # _____

Primary Language	Speaks	Reads	Understands Orally
English			
German			
Spanish			
Sign			
Other:			

Does Customer have any difficulty :	
Communicating	
Understanding information	

Emergency or alternative contact: Relationship _____

Name _____

Address _____

City _____

State _____ Zip _____

Phone (primary) _____

Phone (alternate) _____

Legal Guardian: Relationship _____

Name _____

Address _____

City _____

State _____ Zip _____

Phone (primary) _____

Phone (alternate) _____

Comments:_____

_____

_____

Customer Name _____ Date _____

Uniform Assessment Instrument Scoring		**Long-term Care Threshold Guide**
Definition of Code for Cognition	Code	Multiplier for Threshold Guide
No impairment	0	0
Impairment	1	1
Unable to test	9	0

Cognition	Cog. Code	Multiplier	X	Weight	=	Total	Sum of Cog. scores
Orientation (day of the week, month, year, President)			X	2	=		
3-word recall (pen, car, watch)			X	2	=		
Spelling backward (table)			X	2	=		
Clock Draw (all #'s, spacing of #'s, hands at 11:10)			X	2	=		

Definition of Code for ADL/IADL	Code	Multiplier for Threshold Guide
Independent	1	0
Supervision Needed	2	1
Physical Assistance Needed	3	1
Unable to Perform	4	2

Activities of Daily Living	ADL Code	Multiplier	X	Weight	=	Total	Sum of ADL scores
Bathing			X	4	=		
Dressing			X	3	=		
Toileting			X	5	=		
Transferring			X	5	=		
Walking, Mobility			X	3	=		
Eating			X	4	=		

Instrumental Activities of Daily Living	IADL Code	Multiplier	X	Weight	=	Total	Sum of IADL scores
Meal Preparation			X	5	=		
Shopping			X	3	=		
Money Management			X	4	=		
Transportation			X	3	=		
Telephone			X	3	=		
Laundry, Housekeeping			X	3	=		
Medication Management, Treatment			X	5	=		

RISKS: Current or Recent Problems (check all that apply)	Risk Code	Multiplier	X	Weight	=	Total	Sum of RISKS scores
Falls (Last 1 month _____) (Last 6 month total _____)		1	X	3	=		
Neglect ☐ abuse ☐ and/or exploitation ☐ by others		1	X	5	=		
Informal Support – check appropriate choice		If customer has difficulty in the informal support category, enter 4 at total:					
Yes – there is support *(do not multiply out)*							
Inadequate		Multiplier	X	Weight	=	Total	
No – there is no support		1	X	4	=		
Behavior - check the appropriate choice(s) if any difficulty		If customer has difficult in any behavior category, enter 5 at total:					
Wandering		Multiplier	X	Weight	=	Total	
Socially Inappropriate/Disruptive		1	X	5	=		
Decision Making/Judgment							

Total Score of all Cognition, ADL, IADL and RISKS for Threshold Guide = _____

Was this person on HCBS-FE prior to 7-1-00? Yes ☐ No ☐ Is this a HCBS-PD transfer customer? Yes ☐ No ☐

Comments : _____

_____

_____

Customer Name _____ Date _____

Ask the customer the following questions		
Nutrition Risk Screen	Comments	Score-if yes, circle
Do you eat less than 2 meals daily?		3
Do you eat less than 2 servings of fruits and vegetables daily?		1
Do you eat less than 2 servings of dairy products (milk, cheese, yogurt, etc.) daily?		1
Do you usually drink less than 6 glasses of water, milk, or juice daily?	# of glasses:	0
Do you drink 3 or more alcoholic beverages daily?		2
Do you take 3 or more different prescriptions and/or over-the-counter drugs daily?		1
Do you have problems with dentures, teeth, or mouth, which make it hard to eat?	Which:	2
Have you made changes in the kind and/or amount of food you eat because of an illness and/or condition?	What changes:	2
Are you physically not always able to grocery shop, cook, and/or feed yourself?	Which:	2
Do you eat alone most of the time?		1
Do you feel that you usually do not have enough money to buy the food you need?		4
Have you gained or lost more than 10 pounds in the last 6 months?	Pounds gained ____ lost ____	2
Customer does not meet any of the nutrition risk screen indicators.		0
	Add all the circled scores for a total Nutrition Risk Score	

Would you say that your appetite is:		Do any of the following cause you problems or affect your ability to eat:	
Good		Swallowing	
Fair		Taste	
Poor		Nausea, vomiting	
Comments: _____		Cutting up food	
		Opening containers (milk, plastic wrap, jars)	
		Certain foods, food allergy (specify):	
		No concerns	

How often do you:	Rarely 1 x week	Sometimes 2 x week	Frequently 4-5 x week	Never
Skip meals and just snack, “piece”, through the day?				
Lack the energy or desire to fix a meal?				
Find you don’t know what to fix or can’t fix small portions?				
Forget to turn the stove off or burn food?				
Lack the desire to eat a meal?				
Eat restaurant or fast food?				
Leave home? If not, why?				

What do you eat in a typical day (ask about "breakfast", "lunch", "supper"), describe: _____

Comments (include any special considerations for service delivery such as pets, or "go to back door"): _____

Customer Name _____ Date _____

Ask the customer:
Does anyone help you prepare food or bring food to you? Yes ☐ No ☐ If yes, answer the following:

Who	What	When

Ask the customer:
Are you following any modified diet(s)? Yes ☐ No ☐

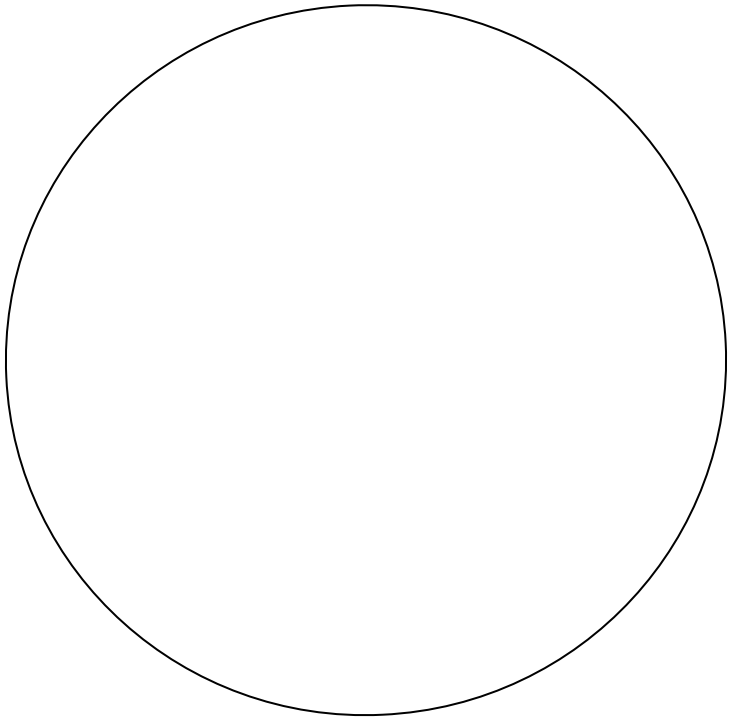
Are any of the modified diets doctor prescribed? Yes ☐ No ☐

Check each modified diet followed:		Check if doctor prescribed and indicate the name of the doctor:	
Low sodium (salt)			
Low sugar			
Low fat/cholesterol			
Renal			
Calorie controlled			
Nutrition supplements			
6 small meals daily			
Vegetarian			
Pureed			
Ethnic/religious			
Other:			

Assessor: Is the customer:	Yes	No
Physically homebound		
Socially homebound		
Isolated		

Participant Status - Home-delivered Meals	
60+ eligible Person	
Spouse, regardless of age, of 60+ eligible Person	
Disabled Person, regardless of age, residing with 60+ eligible Person	
60+ non-spouse Caretaker (IIIB home-delivered meals only)	

Clock Draw



Customer Name _____ Date _____

Primary Diagnosis _____

Source of Information: Customer ☐ Record Review ☐ Other ☐

Customer: Overall, how do you rate your health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Check Health Conditions as Applicable

CARDIOVASCULAR		**INFECTIOUS DISEASE**		**RESPIRATORY**	
Ankle edema		Airborne		Asthma	
By-pass surgery/Angioplasty		Hepatitis		COPD	
Chest pain		Tuberculosis		Cough (dry/productive)	
Circulation problems		Other		Difficulty breathing at any time	
Congestive heart failure		No problem		Emphysema	
Heart attack				Oxygen	
Hypertension		**MUSCULOSKELTAL**		Other	
Hypotension		Amputation of:		No problem	
Pacemaker		Arthritis-rheumatoid or osteo			
Shortness of breath		Back pain		**SKIN**	
Other		Contractures		Pressure/other ulcer	
No problem		Fracture of:		Rashes	
		Joint replacement of:		Shingles	
ENDOCRINE		Osteoporosis		Stasis dermatitis	
Diabetes		Polio/Post Polio		Other	
Thyroid		Other		No problem	
Other		No problem			
No problem				**VISION**	
		NEUROLOGICAL		Blind	
GASTROINTESTINAL		Alzheimer's disease		Blurred vision	
Abdominal pain		Cerebral Palsy		Cataracts	
Colitis		CVA/stroke		Corrective lenses	
Constipation		Dementia		Glaucoma	
Diarrhea		Dizziness		Macular degeneration	
Difficulty swallowing		Paralysis of:		Other	
Diverticular disease		Parkinson's Disease		No problem	
Frequent use of laxatives		Seizures/epilepsy			
Gall bladder problems		Speech problem		**OTHER**	
Indigestion		Transient Ischemic Attack		Alcohol use	
Irritable bowel syndrome		Traumatic brain injury		Alcoholism	
Ulcers		Other		Allergies	
Other		No problem		Anemia	
No problem				Autism	
		REPRODUCTIVE SYSTEM		Cancer	
GENITOURINARY		Enlarged prostate		Developmental disability	
Dialysis		Lumps-breast/node(male, female)		Drug use/abuse	
Difficulty/frequent urination		Mastectomy of:		Mental illness	
Dribbling and/or incontinence		Nipple discharge (male, female)		Mental retardation	
Frequent bladder infections		Prostate cancer		Tobacco use	
Nighttime urination/Nocturia		Vaginal discharge		Obesity	
Other		Other		Significant weight loss/gain	
No problem		No problem		Other	
				No problem	
HEARING					
Deaf		**COMMENTS:**			
Decreased acuity					
Earaches					
Hearing aid					
Other					
No problem					

Customer Name _____ Date _____

Prescription, Over-the-counter, & Herbal Medications/Preparations	Dosage	Frequency	Does the customer know the purpose of the medication? Yes	No	How does the customer remember to take medications? (check all that apply)	
					Calendar	
					Person reminds/gives	
					Egg carton/envelope	
					Pill box or dispenser	
					Follow label directions	
					Other:	
					Other:	
					If set-up, reminded, or given by another, by whom? How often?	

Does the customer have any drug sensitivities? Yes ☐ No ☐ If yes, what: _____

_____

Assessor: Do you have any concerns regarding use of medication or drugs by the customer? Yes ☐ No ☐ If yes, what concerns: _____

_____

_____

Ask the customer the following questions:	Yes	If yes, then ask:	No
Do you have a "Durable Power of Attorney for Health Care Decisions"?		Who?	
Do you have a "Living Will"?		Where?	
Do you have "Do Not Resuscitate" orders?		Where?	
Do you see a doctor regularly?		How often?	
Have you been hospitalized or to the emergency room in the last three months?		How many times?	
Have you been admitted to a nursing home within the last twelve months?		How many times?	

Comments: _____

SPECIAL EQUIPMENT/ASSISTIVE DEVICES (check all that apply)

	Uses	Needs		Uses	Needs
Adaptive eating equipment			Medical phone alert		
Bathing equipment			Ramps (example – wheelchair)		
Brace (leg, back), prosthesis			Supplies (example – incontinence pads)		
Cane, crutches			Toilet equipment		
Dentures			Transfer equipment		
Diabetic supplies			Walker		
Glasses, contact lenses			Wheelchair (manual, electric)		
Hearing aid(s)			Other:		
Hospital bed			Other:		

Customer Name _____ Date _____

Assessor: Ask the customer how he/she has been feeling during the past 4 weeks. For each question, please mark the level that best describes how often she/he had this feeling.

In the last 4 weeks, about how often did you feel….	All of the time (4 pts)	Most of the time (3 pts)	Some of the time (2 pts)	A little of the time (1 pt)	None of the time (0 pt)	Don't know (0 pt)	Refused (0 pt)
… so sad that nothing could cheer you up?							
… nervous?							
… restless or fidgety?							
… hopeless?							
… everything was an effort? (If necessary, for question *e.g.,* prompt: How often did you feel everything was hard and difficult to do?)							
… worthless?							
(Score 13 or higher, offer a referral for your customer)					Total Score		

In the past 4 weeks, how many times have you seen a doctor or other health professional about these feelings?

No visits reported_____ Number of visits _____ Don't know _____ Refused _____

Comments:_____

_____

Ask the customer:
Have there been any major changes, or disruptions in your life that you would like to talk about?
Yes ☐ No ☐ If yes, what: _____

_____

_____

Do any items checked on this page adversely effect:

Customer		Explain: _____
Caregiver		_____
Other		_____
No concerns		_____

Does the customer have a primary caregiver?
Yes ☐ No ☐
If yes, name: _____

Is the primary caregiver overwhelmed in providing care?
Yes ☐ No ☐ If yes, explain in comments.

Comments:_____

_____

_____

_____

_____

Medical Personnel	Phone
Doctor:	
Pharmacy:	
Home Health:	
Hospital:	

Assessor: Are you making or recommending any referrals to (check all that apply):	
Mental health services	
Adult Protective Services	
Community Developmental Disability Org.	
Medical/Home Health	
Other:	
Other:	
Other:	

Comments:_____

_____

_____

_____

Customer Name _____ Date _____

Place of Residence:		Residence Is:		Does the customer have any difficulty getting into their home or any room in their home (check all that apply):	
Apartment, condominium		Government subsidized		Basement	
Assisted living		On Reservation		Bathing facility, bathtub	
Boarding care home		Owned, with payment		Bedroom	
Duplex		Owned, no payment		Entrances	
Home Plus		Rented		Garage	
Homeless		Rent free from _____		Kitchen	
House, townhouse		Other		Laundry area	
Mobile home		Comments:		Living, family room	
Nursing home				Porch	
Residential health care				Toilet facility	
Other				No difficulty	
Comments:				Comments:	

Does the customer's home have:	Working	Not working	Does not have
Air conditioner, fan			
Electricity			
Flush toilet			
Gas, propane			
Heating system			
Microwave			
Piped water, hot/cold			
Radio, television			
Refrigerator, freezer			
Smoke detector			
Stove, hot plate, oven			
Telephone			
Tub, shower			
Washer			
Dryer			
Comments:			

Customer: Do you feel safe	Yes	No
inside your home		
outside your home		
Is there anything inside or outside your home that you are worried or uncomfortable about?		

Explain if the customer does not feel safe or if they have additional concerns: _____

Does the home have health or physical safety issues (check all that apply):	
Animals, pets	
Dirt, garbage	
Furnishings, rugs	
House, basement	
Pests	
Poor lighting	
Stairs	
Yard, storage buildings	
Other	
No problems	
Comments:	

Recommended changes to the customer's environment and/or situation (check all that apply):	
Bathroom modification	
Accessibility modification	
Weatherization	
Other:	
Other:	
No recommendations	

Referrals: _____

Are there special considerations for service delivery such as smoking, pets, or "go to the back door"?

Explain: _____

Customer Name _____ Date _____

Family Size ☐ (Family will include customer, spouse, and minor children living together.)

MONTHLY GROSS INCOME

Type of Income	Customer	Spouse	Minor Child	Total	Comments (note benefit numbers)
Social Security (SSA)					
Social Security Disability (SSD)					
Supplemental Security Income (SSI)					
Retirement pension					
Veteran pension					
Gross earnings from employment, self-employment					
Income from property					
Farm income (adjusted net income)					
Interest, dividends					
Coop dividends, royalties, etc.					
Regular support from family/others					
Cash from SRS					
Other					
Other					
Monthly Total Income (Remember to check poverty level on page 1)					

Percent of customer responsibility for co-pay program:

SCA _____ %

Other _____ %

Other _____ %

Name/address if bill for co-pay is to be sent to someone other than customer:

_____

_____

_____

Customer: Do you need legal assistance? Yes ☐ No ☐

Customer: Do you want a referral for SRS assistance?

Financial: Yes ☐ No ☐ Already received ☐

Medical: Yes ☐ No ☐ Already received ☐

Food Stamps: Yes ☐ No ☐ Already received ☐

SRS Specialist: _____

Supplemental Insurance:

Company _____

Policy # _____

Premium amount $ _____

Designated person for financial matters: Self ☐ Other ☐

Durable Power of Attorney ☐ Conservator ☐

Relationship _____

Name _____

Address _____

City _____

State _____ Zip _____

Phone, home _____

Phone, work _____

Comments: _____

_____

_____

_____

_____

Customer Name _____ Date _____

(1) Does the customer have liquid assets such as Cash (deposited or not), Certificates of Deposit (CD), Stocks or Bonds in excess of the following (If unsure complete item #2 below):

$10,001 for a 1 Person Family
$13,501 for a 2 Person Family
$17,001 for a 3 Person Family
$20,501 for a 4 Person Family (Exempt $3,500 for each additional person)

_____ Yes. Proceed to question 2.
_____ No. Stop, you do not need to proceed.
_____ Refused to provide income or asset information.

(2) Identify the approximate value for each of the following described assets.

+_____ Checking/Cash on Hand
+_____ Savings
+_____ Bonds
+_____ Certificates of Deposit (CD)
+_____ Individual Retirement Account (IRA)
+_____ Life Insurance (Cash Value)
+_____ Money Market
+_____ Mutual Funds
+_____ Savings Bonds
+_____ Stocks

Name of Stock (Name not entered in KAMIS)	# of shares	x	Last sale value	=	Stock Value
		X		=	
		X		=	
		X		=	
		X		=	

Total Stock Value _____
(enter this value on stocks)

==========

_____ Total Gross Liquid Assets

(3) Match the customer's monthly income (page 9) and gross liquid assets (page 9 Supplemental) to the SCA sliding fee scale to determine the percentage the customer is required to pay for monthly services.

_____ Total % of monthly customer responsibility.
(Record on Page 9 of the UAI)

HCBS/FE EXPEDITED SERVICE DELIVERY FINANCIAL SCREENING WORKSHEET

Customer Name: _____ **Soc. Sec. #:** _____

(1) Does the customer want HCBS?	☐ Yes, move to next question	☐ No, stop process
(2) Does the customer still plan to apply for Medicaid after Estate Recovery is explained to the customer or their legal representative?	☐ Yes, move to next question	☐ No, stop process ☐ Already has Medicaid, move to next question
(3) Is the customer already eligible for SSI?	☐ No, move to next question	☐ Yes, move to next question
(4) Is the customer already eligible for Medicaid?	☐ No, move to next question	☐ Yes, move to next question

Question	**(A) Continue If Checked**	**(B) Stop, do not Expedite**	**Section on Med. App. ES-3100.1**
(5) Is the customer a U.S. citizen and a resident of Kansas?	☐ Yes	☐ No	Section B, p. 2 and B, p. 1
(6) *From Resource Table at bottom of page:* Are the customer's total resources less than $2,000? If the customer has community spouse, are the couple's resources less than or equal to $20,328?	☐ Yes	☐ No	Section I, p. 6, 7
(7) Does the customer or spouse have a trust fund or an annuity?	☐ No	☐ Yes	Section I, p. 7
(8) Does the customer or spouse have a life estate in property?	☐ No	☐ Yes	Section I, p. 7
(9) Has the customer or spouse transferred property within last 5 years?	☐ No	☐ Yes	Section I, p. 7, 8
(10) Does the customer have a monthly income of less than $747?	☐ Yes	☐ No	Section J & K, p. 8, 9
(11) Is the customer or spouse self-employed (includes farming)?	☐ No	☐ Yes	Section J, p. 8
(12) Is the customer's monthly POC amount less than $4,000?	☐ Yes	☐ No	UAI p. 10
(13) Does the customer require over the maximum ADL/IADL time limits?	☐ No	☐ Yes	FSM 3.5 Appendix I
EXPEDITE DECISION	If all of the above in (A) are checked, expedite services for this customer.	If at least one of the above in (B) is checked, do not expedite services for this customer.	EXPEDITE? ☐ Yes ☐ No

Resource Table (Source Section I, p. 6, 7, 8)	**Value**
Checking Account	$
Savings Account	$
Stocks & Bonds	$
Funeral Plan or Burial Plan • Up to $5000/person on an irrevocable plan is exempt plus an additional amount for merchandise, enter non-exempt amount.	$
Burial Plots	exempt
Automobiles or other vehicles (Exclude one)	$
Life Insurance (exclude term insurance) • Add together the face value of all policies. If the total is less than or equal to $1,500 they are exempt. If the total is greater than $1,500, enter the total of the cash values.	$
Home(s) • If the customer owns a home and resides in it, it is exempt. Enter zero. • If the customer owns a home but does not reside in it, do they intend to return home? ❖ If yes, enter zero. ❖ If no, is there a spouse or dependent child living there? ○ If yes, enter zero. ○ If no, enter value of non-exempt home.	$
Other property (land, buildings)	$
Other assets (cash, trailers, boats, oil/mineral rights, NF personal fund account)	$
Total Resources	$

Customer _____ Address _____ Phone # _____

Medicaid # _____ KAMIS ID # _____ Other agency identifier _____

Emergency Contact _____ Relationship _____ Phone: home _____ work _____

AAA/ CME	Service Code	Funding Source	Provider	Unit(s)	Per	Total Units Monthly	Start Date	End Date	Dis-charge Code	Cost of Unit	Customer Obligation/ Copay	Monthly Cost

Unmet Need Service Code, Availability Code, Monthly Number of Units

Service Code	Availa-bility	Units	Service Code	Availa-bility	Units

SCA total cost including customer copay:

OAA total cost:

Total customer obligation/copay:

HCBS/FE monthly costs including customer obligation: +
(HCBS amount must be reported to EES Specialist)

Medicaid Average Acute Care Cost: =

HCBS/FE Total Cost:

Release of Information: I consent to the release of the information on this page so I can receive services. I understand the information included in these pages 1-10 will be released to Kansas Department on Aging and service providers listed above to enable the delivery of services and program monitoring.

_____ _____ _____
Customer or Guardian Signature Date Assessor Signature & Phone #

_____ _____ _____
Customer or Guardian Signature Date Assessor Signature & Phone #

Additional Support/Services from Home Health, Family, Friend, Neighbor, Attorney, Landlord, Church, Club, Other

Name	Relationship (check if primary caregiver)		Address (indicate "same" if lives with customer)	Phone		Service	Frequency	Paid	
				Home	Work			Yes	No